

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

7844

Do not use this space.

## 1. PLACE OF DEATH

(a) County Putnam

(b) Township Elm

(c) City

(d) Street No.

Registration District No. 719

Primary Registration District No. 7-250

Registered No. 3

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 2505 Viverster Lawson

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

## 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Angeline LAWSON

## 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Nov. 22 - 1862

## 7. AGE

YEARS

77

## MONTHS

2

## DAYS

26

If LESS than 1 day, — hrs. or — min.

## OCCUPATION

## 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

Farmer

## 9. Industry or business in which work was done, as saw mill, bank, etc.

Farmer

## 10. Date deceased last worked at this occupation (month and year)

## 11. Total time (years) spent in this occupation

## 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Iowa

## FATHER

## 13. NAME

Thomas Lawson

## 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Iowa

## MOTHER

## 15. MAIDEN NAME

Mary Walker

## 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Maryland

## 17. INFORMANT (ADDRESS)

Albert H. Hester

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE CALIN Ford Cem. DATE Feb-19, 1940

## 19. FUNERAL DIRECTOR (NAME) (ADDRESS)

F. O. Hustedson, Anianville, Mo.

## 20. FILED March 1, 1940 Marie Martin Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb-18, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1940, to Feb 18, 1940

I last saw him alive on Feb 16, 1940. Death is said

to have occurred on the date stated above, at 8:20 P.M.

The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis

Other contributory causes of importance: Atherosclerosis of all the arteries

Name of operation none

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H. P. Garrison M.D.

(Address) Nowinger Mo

RECEIVED

District Health Officer No. 10

District File Number 3-40-549

Date Filed MAR 8 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Wm E. Husted*

Licensed Embalmer No.

*3384*

P. O. Address

*Unionville Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.